DEPARTMENT OF SUBSTANCE ABUSE PROGRAMS (DSAP)

Metropolitan Assessment & Treatment Services (MATS)

Supportive Aftercare Community (SAC)

Program Application

(PLEASE PRINT CLEARLY)

Fax: 505-462-9857

Date Received:_____

Staff Complete Only

Last Name:	**MI:**	**First Name:**
Date:	DOB: / /	Age:
Gender:	SSN:	
Race/Ethnicity:	Currently Employed: Y N How long: Employer:	
Marital Status:	Are you a Veteran: Y N Branch: Discharge Date: Type of Discharge:	

Briefly describe current living arrangements: _____
(Relatives, Homeless, Shelter, Renting)

_____

_____

Primary or Preferred Language:	Religious Preference (If any):
Annual Income Level: (Please Circle) $0 $1-9,999 10,000-19,999 20,000+ What income do you receive? (SSI, SSDI, VA Disability, Employment, etc.)	Highest Level of Education: _____ (Completed) Have you ever applied for HSD Benefits? Y N Are you eligible for food stamps? Y N

Have you ever participated in a Bernalillo County Dept. of Substance Abuse Program before? Y N

(CIRCLE)

MATS DETOX ATP in MDC ATP/AFTERCARE

When:

Do you have pending charges? Y N What charges: Do you have a pending court date? Y N If Yes, When:	Are you currently on Probation or Parole? Y N Probation Officer Contact Info: Parole Officer Contact Info: Do you have any active restraining orders? Y N If yes, with whom and when does it expire?

Emergency Phone Contact: (Name): Phone Number:

What is your relationship to contact person?

Have you ever been diagnosed with a mental health problem(s)? Y N

List Diagnosis:

When & where given Diagnosis: Month / year agency

Are you current receiving disability for a mental health problem? Y N

Are you currently seeing a Psychiatrist/Psychologist/Therapist? Y N

If yes, Name: Contact Number:

Current Medications taken for mental health problems:

Currently Pregnant: Y N Due Date: _____

How many children do you have under the age of 18? _____ How many have lived with you in the last 12 months? _____

	Child Name	Male/Female	Age	Caretaker	If living with you, who will take care of children while in program
1.					
2.					
3.					

If additional, just list names and age:

Do you have any current Medical Problems (list)?

Are you currently receiving disability for a medical problem? Y N

List need for any special accommodations (Ex. Wheelchair, Hearing Impairment needs, Visual impairment needs) :

What is your usual hospital for medical treatment?

Name of primary care doctor (if applicable) : Phone Number:

Any current medications for medical problems?

HAVE YOU EVER BEEN …

Hepatitis Tested Y N When: Result: Type:

HIV Tested: Y N When: Result:

TB Tested: Y N When: Result:

Any known allergies?

Do you currently have Health Insurance? Y N

Ins. Company: Policy #: Contact Number:

Primary Drug (s) of use:

List prior treatment(s) for Substance abuse:

Agency Name | Type of treatment (rehab / detox) | Month / Year attended | How long were you clean/sober after treatment?

1. _____

2. _____

3. _____

Drug Type	Age at 1st Use	Any use in last 12 months (yes – no)	Date of Last Use (Month/Year)	Approx. Amount (ex. $60 daily)	Route of use (IV, Smoke, Oral)
Alcohol					
Benzodiazepines (Xanax, Klonopin, Ativan, Serax, Valium)					
Heroin					
Methamphetamine					
Crack					
Cocaine (powder)					
Marijuana					
Methadone					
Inhalants					
Hallucinogens (LSD, Mescaline, DMT)					
Prescription Meds. (OxyContin, Percocet, Oxycodone, Vicoden, Morphine)					
Other (please describe)					

Have you ever been arrested for Domestic Violence? Y N How many times? _____

Have you ever been arrested for DWI? Y N How many times: _____ What Year(s): _____

Other Arrests in last 12 months (Please List) _____

Have you ever been convicted of a felony? Y N If yes, charge and year _____

_____

Any additional add here:

How do you generally handle your anger?

What would you consider to be your triggers to use to use?

What has worked in the past to keep you from using drugs or alcohol?

Did your parents use any substance(s) while you were growing up? Y N

How many siblings in your immediate family?

Were you ever abused? Y N

In what way (circle all that apply): Emotional Physical Sexual

Admission Statement:

By your signature below, you hereby acknowledge that all the information you have given on this application Is true to the best of your knowledge. Please be aware that the giving of false, misleading, or incomplete Information may result in your application being denied and/or services being terminated.

Do you understand this statement? Y N

Signature

Applicant: _____ Signature: _____
PRINTED NAME

Contact Phone Number: _____ Date: _____

PLEASE GIVE A STATEMENT IN YOUR OWN WORDS AND IN YOUR OWN WRITING ABOUT WHY YOU FEEL RECOVERY IS POSSIBLE IN YOUR LIFE AT THIS TIME AND HOW YOU SEE THIS PROGRAM HELPING YOU IN YOUR RECOVERY PROCESS.

_____

_____

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